	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155237		(X2) MUL A. BUILD		ONSTRUCTION 01	(X3) DATE COMPL 03/25/	ETED
		199297	B. WING	CED FEET.	A DODDEGG CHEW CHATE THE CODE	03/23/	2013
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE SHELBY ST		
BETHAN	Y VILLAGE NURS	ING HOME			APOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	l `	NCY MUST BE PRECEDED BY FULL P. I. S.C. IDENTIFYING INFORMATION		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
K010000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	+	TAG	BHICKETY		DATE
101000							
	A Life Safety C	ode Recertification and	K010	000			
	1	Survey was conducted by					
		e Department of Health in					
		n 42 CFR 483.70(a).					
		()					
	Survey Date: 0	3/25/13					
	Facility Number	r: 000142					
	Provider Number						
	AIM Number: 100266940						
	Alivi Nullibel.	100200940					
		k Caraher, Life Safety					
	Code Specialist						
	At this Life Safe	ety Code survey, Bethany					
		Home was found not in					
	1 -	h Requirements for					
		Medicare/Medicaid, 42					
		33.70(a), Life Safety from					
	_	00 Edition of the National					
		Association (NFPA) 101,					
		le (LSC) and 410 IAC					
	1	0101 was surveyed using					
	1	sting Health Care					
	Occupancies.	Sting Heartin Care					
	o companionos.						
	This one story f	acility was surveyed as					
	1	ildings due to the					
	_	tes of two sections of the					
		ing 0101 was determined					
	1	(000) construction and					
		d. The facility has a fire					
	Tarry Sprinkicies	a. The facility has a fife					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	LDING	NSTRUCTION 01	(X3) DATE COMPL 03/25/	ETED
NAME OF I	PROVIDER OR SUPPLIEF			DDRESS, CITY, STATE, ZIP CODE SHELBY ST		
BETHAN	Y VILLAGE NURSI	NG HOME		APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	corridors and in corridor. The fa hard wired to the installed in all return The facility has a census of 87 at All areas where access were spriproviding facility sprinklered, excestorage shed. Quality Review Safety Code Specon 03/28/13. The facility was with the aforement	th smoke detection in the all areas open to the cility has smoke detectors a fire alarm system esident sleeping rooms. It is a capacity of 100 and had at the time of this visit. The residents have customary makered. All areas are services were cept for one detached by Robert Booher, Life recialist-Medical Surveyor found not in compliance centioned regulatory evidenced by the				

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Event ID: 278121

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155237	B. WIN	G		03/25/	2013
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					SHELBY ST		
BETHAN	Y VILLAGE NURSI	NG HOME		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K010025 SS=E	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
33-E		re constructed to provide at					
		our fire resistance rating in					
		8.3. Smoke barriers may					
		trium wall. Windows are					
		rated glazing or by wired steel frames. A minimum					
		ompartments are provided					
		mpers are not required in					
		of smoke barriers in fully					
	ducted heating, v						
	conditioning syste 19.1.6.3, 19.1.6.4						
		ation and interview, the	K ₀	10025	What corrective action(s) will be	ne.	04/23/2013
		ensure 2 of 2 openings			accomplished for those reside		0 1/25/2015
	_	ng in the mechanical			found to have been affected by		
	_	dry into the attic were			the deficient practice? The tw		
		ovide at least a one half			openings through the ceiling in the mechanical room in the	1	
	•	nce rating. This deficient			laundry into the attic were		
		fect any staff or visitor in			repaired and firestopped on		
	-	e mechanical room in the			4/11/13 by maintenance staff.		
	laundry.	e meenamear room in the			building review was completed 4/11/13 with no further concert		
	iaunary.				in smoke barriers identified. He		
	Findings include				will you identify other Resident		
	Tillulings illerude	·•			having the potential to be affect	cted	
	Based on observ	ations with the			by the same deficient practice and what corrective action will	he	
		rector during a tour of the			taken?Residents currently livir		
		40 a.m. to 1:05 p.m. on			in the facility, visitors, and staf	•	
	-	lowing was noted in the			have the potential to be affected		
	mechanical room				by the alleged deficient		
		•			practice. The two openings through the ceiling in the		
	-	opening in the ceiling			mechanical room in the laundr	v	
	_	nches long by three			into the attic were repaired		
		ugh which two water			and firestopped on 4/11/13 by		
	-	the attic was not			maintenance staff. A building	/4.0	
	firestopped.				review was completed on 4/11 with no further concerns in sm		
	b. the annular sp	ace surrounding a one			with no futurer concerns in sin	OVE	

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	I OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	01	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING B. WING		03/25/2013
	PROVIDER OR SUPPLIER NY VILLAGE NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES	3518 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST APOLIS, IN 46227 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	inch water line which penetrates the ceiling into the attic was not firestopped. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned locations in the mechanical room in the laundry were not firestopped. 3.1-19(b)		barriers identified. What measures will be put into place what systematic changes will make to ensure the deficient practice does not recur? Whe repairs or building damages occurs in the future, facility wireview areas to ensure these areas are maintained to proviat least one half hour fire resistance rating. Another building review will be conducted by 4/23/13 to ensure smoke barriers are being maintained provide at least a one half hour fire resistance rating. An inservice for all staff will by completed by 4/23/13 to educted by Maintenance Supervisor or designee week 4, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice who trecur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly and quarterly thereafter to ensure the data. If 100% threshold is not achieved, an action plan will be developed.	you en II de tted to ur eate pol e y x e will t it x 2, sure ed east e iii

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Event ID: 278121

Facility ID: 000142

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155237	B. WIN	G		03/25/	2013
NAME OF B	DOLUDED OD GUDDU IED			STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			3518 S	SHELBY ST		
BETHAN	Y VILLAGE NURSII	NG HOME		INDIAN	NAPOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010044	NFPA 101						
SS=E	LIFE SAFETY CO						
	with 7.2.4. 19.2	f used, are in accordance					
		ation and interview, the	K01	10044	What corrective action(s) will I	oe .	04/23/2013
		ensure 1 of 1 fire barrier			accomplished for those reside	nts	
	walls was mainta	nined to provide a two			found to have been affected b	У	
	hour fire resistance rating. LSC 7.2.4.3.1 requires fire barriers separating building areas where there are horizontal exits shall have a 2 hour fire resistance rating				the deficient practice? The drywall of the attic fire barrier	wall	
					was repaired and firestopped		
					4/5/13 to ensure the two hour		
					rating of the fire barrier. How you identify other Residents	WIII	
	and shall provide	e a separation that is			having the potential to be affe	cted	
continuous to ground. This deficient				by the same deficient practice			
	practice could affect 26 residents, staff				and what corrective action will		
	and visitors near	the Activities Room.			taken?Residents currently living the facility visitors, and state	-	
					in the facility, visitors, and state have the potential to be affect		
	Findings include	:			by the alleged deficient	ou	
					practice. The drywall of the at		
	Based on observa	ation with the			fire barrier wall was repaired a		
	Maintenance Dir	rector during a tour of the			firestopped on 4/5/13 to ensur the two hour fire rating of the f		
	facility from 10:4	40 a.m. to 1:05 p.m. on			barrier. A building review was		
	03/25/13, a two l	hour rated fire barrier is			completed on 4/11/13 with no		
	in the attic above	e the corridor doors by the			further concerns in smoke and	t	
	Activities Room.	One layer of the four			fire barriers identified. What measures will be put into plac	e or	
		thths inch thick drywall			what systematic changes will		
	of the attic fire b	arrier wall had a four			make to ensure the deficient		
	inch in diameter	hole in the layer which			practice does not recur? Whe	en	
		ped to maintain the two			repairs or building damages occurs in the future, facility wil	ı	
		of the fire barrier. The			review areas to ensure these	ı	
	_	ich had the opening was			areas are maintained to provide	de a	
		of the wall. Based on			two hour fire rating of the		
		time of observation, the			fire barriers. Another building		
		ector acknowledged the			review will be conducted by 4/23/13 to ensure fire barriers	are	
		mentioned attic fire			being maintained to provide a		
		not maintain the two hour			least a two hour fire rating of t		
	Carrior Warr and I		1		I		

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PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155237		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPI 03/25	LETED	
	PROVIDER OR SUPPLIER		STREET . 3518 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST JAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIEGE TO THE APPROPRIEGE OF THE APPROPRIE	or all 23/13 ess of Life zed by ally x 2, bw the ficient what will be y It to ting of mittee 6 n	(X5) COMPLETION DATE

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Event ID: 278121

Facility ID: 000142

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155237	B. WING		03/25/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	£	3518 S	SHELBY ST	
BETHAN	Y VILLAGE NURSI	NG HOME	INDIAN	IAPOLIS, IN 46227	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K010056	NFPA 101	ODE STANDARD			
SS=A		omatic sprinkler system, it is			
		dance with NFPA 13,			
	Standard for the Installation of Sprinkler Systems, to provide complete coverage for				
	•	building. The system is			
		ned in accordance with			
		ard for the Inspection,			
	•	ntenance of Water-Based ystems. It is fully			
		re is a reliable, adequate			
	•	the system. Required			
	sprinkler systems are equipped with water flow and tamper switches, which are				
		ected to the building fire			
	,	19.3.5			
		ation and interview, the	K010056	What corrective action(s) will be	04/23/2013
	•	install an automatic		accomplished for those residents	
	•	in 1 of 1 Maintenance		found to have been affected by the	
	Office areas in a	ccordance with NFPA 13,		deficient practice? The sprinklers in the Maintenance office are to be	1
	1999 Edition, In	stallation of Sprinkler		repaired by 4/19/13 so that they ar	<u> </u>
	Systems. NFPA	13, Section 5-6.3.4,		at least six feet apart. A building	
	Minimum Distar	nce Between Sprinklers,		review was completed on 4/11/13	
	states sprinklers	shall be spaced not less		with no further concerns in spacing	
	than six feet (72	inches) on center. This		of sprinklers. How will you identify	
	deficient practic	e could affect two staff		other Residents having the potentia	
	and visitors in th			to be affected by the same deficien	t
	Maintenance Of	•		practice and what corrective action will be taken?Residents currently	
				living in the facility, visitors, and sta	ff
	Findings include	··		in the vicinity of the Maintenance	"
	i manigo merado			office have the potential to be	
	Dagad an abar	ection with the		affected by the alleged deficient	
	Based on observ			practice. The sprinklers in the	
		rector during a tour of the		Maintenance office are to be	
	-	40 a.m. to 1:05 p.m. on		repaired by 4/19/13 so that they ar	e
		f the three sprinklers in		at least six feet apart. A building	
	the Maintenance	Office were installed		review was completed on 4/11/13	
				1	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED	
		155237	B. WIN	G		03/25/2013	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE SHELBY ST		
BETHAN	Y VILLAGE NURSI	NG HOME		INDIAN.	APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	four feet apart fr same sprinkler p corridor wall inte interview at the Maintenance Dir of three sprinkle Maintenance Of	om one another on the ipe protruding from the of the room. Based on time of observation, the rector acknowledged two installed in the fice were installed less art from one another.			with no further concerns in spacing of sprinklers. What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? When repairs, building damages, or building modifications occurs in the future, facility will review areas to ensure that sprinklers on automatic sprinkler system are spaced no less than six feet apart. Another building review will be conducted by 4/23/13 to ensure the repair of the sprinklers in the Maintenance office was completed and spaced at least feet apart. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designe weekly x 4, monthly x 2, and quarterly thereafter to ensure sprinklers are spaced no less than sifeet apart. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	e e e y e f f f f f f f f f f f f f f f	

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Event ID: 278121

Facility ID: 000142

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155237		A. BUILDING 01 COMPI			(X3) DATE S COMPL: 03/25/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 3518 S	ADDRESS, CITY, STATE, ZIP CODE SHELBY ST APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K010062 SS=C	continuously main condition and are periodically. 19 NFPA 25, 9.7.5 Based on record interview; the far quarterly sprinkly conducted for the of 4 calendar quast standard for the Maintenance of Protection System waterflow alarm not limited to me vane type waterf pressure switche or visual signals NFPA 25, 1-8 reinspections and its system and its converse available to the angurisdiction upon practice could after and visitors in the Findings included Based on a review Inspection document of the production of the pr	tic sprinkler systems are natained in reliable operating inspected and tested 1.7.6, 4.6.12, NFPA 13, review, observation and cility failed to ensure er inspections were esprinkler system for 1 arters. NFPA 25, Inspection, Testing, and Water-Based Fire ms, 2-3.3 requires devices including, but echanical water gongs, low switches and s which provide audible shall be tested quarterly. quires records of tests of the sprinkler omponents shall be made authority having a request. This deficient effect all residents, staff e facility.	K01	0062	What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? The sprinkler system inspection repedated 12/27/12 was received of 4/5/13 and placed in Maintenar records for future review. How will you identify other Resident having the potential to be affect by the same deficient practice and what corrective action will taken? Residents currently living in the facility, visitors, and staff have the potential to be affect by the alleged deficient practice. The sprinkler system inspection report dated 12/27/12 was received on 4/5/13 and placed Maintenance records for future review. First quarter 2013 sprinkler system inspection was completed on 3/28/13 and is being maintained in Maintenar records for further review. What measures will be put into place what systematic changes will ymake to ensure the deficient practice does not recur? Sprin system inspections will be conducted quarterly. Sprinkler system reports will be kept in Maintenance Supervisor office A Life Safety audit tool for sprinkler system inspection	nts y port on nce y ts ted be ng f ed ee. n in ee sance t eo t cou kler	04/23/2013

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING	ſ	COMPLETED
	155237	B. WING		03/25/2013
	PROVIDER OR SUPPLIER Y VILLAGE NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES	3518 S SHEL	ESS, CITY, STATE, ZIP CODE LIBY ST LIS, IN 46227 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX CRC	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE
	the fourth quarter 2012 (October, November, December) sprinkler system inspection was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fourth quarter 2012 sprinkler system inspection was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:05 p.m. on 03/25/13, a fourth quarter 2012 quarterly sprinkler inspection date was not written on the hanging tag P.I.P.E. had affixed to the sprinkler system riser to document quarterly sprinkler inspections. 3.1-19(b)	Sup 4, m there the r for c and avai corr mon prac qual put i audi Main desi and ensu qual and avai com	be utilized by Maintenance pervisor or designee weekly monthly x 2, and quarterly reafter to ensure requirement is met quarterly sprinkler inspection designated and allable for review. How the rective action(s) will be nitored to ensure the deficienctice will not recur, i.e. what allity assurance program will into place? A Life Safety dit tool will be utilized by intenance Supervisor or signee weekly x 4, monthly and quarterly thereafter to sure the requirement is metal allable for review. The CQI mmittee will review the data. D% threshold is not achieved action plan will be developed.	ns ent be < 2, for If d,

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Event ID: 278121

Facility ID: 000142

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	02	COMPL	
		155237	B. WIN	G		03/25/	2013
NAME OF D	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			3518 S	SHELBY ST		
BETHAN	Y VILLAGE NURSII	NG HOME		INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K020000							
	A Life Sefety Co	ada Pagartification and	VO	20000			
	A Life Safety Code Recertification and State Licensure Survey was conducted by		KU2	20000			
	the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/25/13						
	Survey Date. 03	723/13					
	Facility Number:	: 000142					
	Provider Number: 155237 AIM Number: 100266940						
	Surveyor: Mark	Caraher, Life Safety					
	Code Specialist						
	•						
	At this Life Safe	ty Code survey, Bethany					
		Home was found not in					
		Requirements for					
	•	Medicare/Medicaid, 42					
	•	3.70(a), Life Safety from					
	_	D Edition of the National					
		Association (NFPA) 101,					
		, , , , , , , , , , , , , , , , , , , ,					
		e (LSC) and 410 IAC					
	-	202 consisting of the					
		vas surveyed using					
	Chapter 18, New	Health Care					
	Occupancies.						
	D :11: 0202	1: 2012					
	_	onstructed in 2012 was					
		of Type V (000)					
		fully sprinklered. The					
	facility has a fire	alarm system with					
	smoke detection	in the corridors and in all					

FORM CMS-2567(02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	(X2) M A. BUII B. WIN	LDING	nstruction 02	(X3) DATE COMPL 03/25/	ETED
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE SHELBY ST	<u> </u>	
BETHAN	Y VILLAGE NURSI	NG HOME			APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	has smoke detect alarm system installed sleeping rooms. capacity of 100 at the time of this was access were spring providing facility.	residents have customary nklered. All areas					

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Facility ID: 000142

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